Kansas State Board of Pharmacy
800 SW Jackson, Ste. 1414
Topeka, KS 66612
Phone: 785-296-4056
Fax: 785-296-8420
www.kansas.gov/pharmacy

APPLICATION FOR REGISTRATION
DURABLE MEDICAL EQUIPMENT

APPLICANT INSTRUCTIONS

Basic Requirements: Requirements for registration are outlined in the Kansas Pharmacy Act, specifically K.S.A. 65-1626 (s); K.S.A. 65-1627; and K.S.A. 65-1645, and the Board rules. Both can be found at www.kansas.gov/pharmacy.

About the Application. This application is to be completed by you and returned to the Kansas State Board of Pharmacy. All questions on the application are mandatory, and all supporting documents must be submitted with the application. You may copy as many forms as needed; however, each form submitted must be completed in original ink or typed. Be sure to keep a copy of the completed application for your records. If application is sent without attached documents, Kansas State Board of Pharmacy may contact the applicant.

Application good for One Year. Your application will be kept on file for one year from date of receipt. You will need to resubmit a renewal form and fee after that time.

Applicant Checklist

For registration approval and changes to existing registrations, you must submit in one complete package:

_____ **Completed application with the non-refundable application-processing fee.**

_____ **A copy of the current pharmacy or permit license issued by the state of residence.**

_____ **Ownership List and Information.**

_____ **A copy of the most recent report of inspection conducted within the past two years by the Board or Department of the state of residence.**

Return your completed application packet and all supporting documents to:

Kansas State Board of Pharmacy
800 SW Jackson, Ste.1414
Topeka, KS 66612

FOR OFFICE USE ONLY

REG NO. _____

DATE _____

Check # _____$___

KANSAS STATE BOARD OF PHARMACY
800 SW JACKSON ROOM 1414
TOPEKA KS 66612
(785) 296-4056
FAX (785) 296-8420

FEE $ 240.00

APPLICATION FOR **DURABLE MEDICAL EQUIPMENT** REGISTRATION

This application is being made for the following reason: (Check all that apply) Effective Date _____

_____Original _____Change of Address _____Change of ownership _____ Change of business name

If a Change of Address: Previous License Number or Name (if applicable)_____

Or Previous Address_____

The owner hereby makes application as follows:

_____
NAME OF OWNER FEIN

_____
ADDRESS OF OWNER

CITY STATE ZIP

TELEPHONE FAX NUMBER E-MAIL ADDRESS

Type of ownership (Check one):

_____INDIVIDUAL

_____PARTNERSHIP Attach additional listing of each partner's name, address of record and % ownership.

_____CORPORATION Attach additional listing of officer's name, title, address of record and % ownership.

_____LLC Attach additional listing of members. Include name, title, address of record and % ownership.

_____OTHER Indicate type:_____

The owner makes application for registration to supply durable medical equipment to the patient in the State of Kansas under the name of and at the location as follows:

_____
TRADE NAME/BUSINESS NAME USED BY THE ENTITY Hours of Operation

_____
PHYSICAL ADDRESS **(DME's CANNOT BE LICENSED AT PRIVATE RESIDENCES)**

_____
CITY STATE ZIP COUNTY

TELEPHONE E-MAIL WEBSITE

_____
MAILING ADDRESS IF DIFFERENT THAN PHYSICAL LOCATION FOR RENEWAL INFORMATION

_____
CITY STATE ZIP

TELEPHONE NUMBER FAX NUMBER E-MAIL ADDRESS

The owner names the following person as the contact agent/authorized representative to do business with the State of Kansas on the owner's behalf:

NAME OF CONTACT AGENT/AUTHORIZED REPRESENTATIVE TITLE

TELEPHONE NUMBER E-MAIL ADDRESS

SERVICES PROVIDED (Check all that apply):

_____ Oxygen & Oxygen Delivery Systems _____Ventilators _____Respiratory disease management devices

_____ Continuous positive airway pressure (CPAP) _____Electronic and Computerized wheelchairs and seating systems

_____Apnea Monitors _____Transcutaneous electrical nerve stimulator (TENS) units _____Feeding Pumps

_____Low air loss cutaneous pressure management devices _____home phototherapy devices _____infusion delivery devices

_____Sequential compression devices _____distribution of medical gases to end users for human consumption

_____hospital beds _____ nebulizers _____ other items that contain the Federal Caution statement

If oxygen is checked above:
Do you transfill or repackage oxygen? _____Yes _____No If yes, please provide FDA number: _____

Please attach a copy of the approved cylinder label that is being used.

QUESTIONS

1) Has the applicant, or any of the applicant's employees or associates, ever been excluded from Medicare participation? ___Yes _____No

2) Has the applicant, or any of the applicant's employees or associates, had a disciplinary action taken by the federal or state government of any license(s) held by an employee or associate? _____Yes _____ No

3) Has the applicant, or any of the applicant's employees or associates, ever been convicted of a felony? _____Yes _____ No

4) Is any action pending in any of the above? _____Yes _____No

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AFFADAVIT

I, _____, solemnly swear (or affirm) under the penalties of perjury, that I am the person authorized to sign this application for registration and that the statements and representations made in the foregoing application and all attachments are true and correct to the best of my knowledge and understands that this registration, if issued, will expire ANNUALLY on the 30th day of June and such registration will be cancelled if not renewed ANNUALLY by the 31st day of July.

_____
SIGNATURE OF OWNER/OFFICER

Signed and sworn to (or affirmed) before me on _____ day of _____, 20_____.

(Seal)

My commission expires _____ _____
SIGNATURE OF NOTARY PUBLIC